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http://www.irdes.fr/english/documentation/watch-on-health-economics-literature.html

SOMMAIRE

Assurance Maladie / Health Insurance

(2013). Réformer et améliorer le système de Santé grâce au privé et à la concurrence. La France face aux exemples allemands, suisses et néerlandais : Paris : IREF
Abstract: L'IREF propose une étude comparative des régimes d'assurance maladie dans quatre pays : la France, les Pays-Bas, l'Allemagne et la Suisse. Ce comparatif est d'autant plus pertinent que certains pays, comme l'Allemagne et les Pays-Bas ont récemment entamé des réformes visant à renforcer le rôle du secteur privé et de la concurrence pour permettre un désengagement de l'Etat dans le secteur de l'assurance maladie. Les réformes allemandes et néerlandaises ont permis l'émergence d'une concurrence entre les caisses d'assurances. La qualité des soins n'a pas diminué et dans le cas des Pays-Bas, la qualité a même augmenté depuis la réforme de 2006. En Allemagne, les personnes avec des revenus à partir de 4 050 euros brut/mois sont libres de choisir un système d'assurance santé totalement privé. Le résultat de l'étude met surtout en évidence la supériorité du système néerlandais qui fonctionne à l'image d'un partenariat public-privé dans lequel l'Etat prélève des cotisations destinées à fournir des soins de qualité aux moins de 18 ans ainsi qu'aux ménages à faibles revenus (résumé d'auteur).
http://fr.irefeurope.org/Reformer-et-ameliorer-le-systeme-de-Sante-grace-au-prive-et-a-la-concurrence,a2586#sommaire

Boes S. G. (2013). Does full insurance increase the demand for health care? Bern : Bern Universität
Abstract: We estimate the causal effect of having full health insurance on health care expenditures. We take advantage of a unique quasi-experimental setup in which deductibles and co-payments were zero in a managed care plan, and non-zero in regular insurance, until a policy change forced all individuals with an active plan to cover a minimum amount of their expenses. Using panel data and a non-linear difference-in-differences strategy, we find a demand elasticity of about -0.14 comparing full insurance with the cost-sharing model, and a significant upward shift in the likelihood to generate costs.
http://www.vwl.unibe.ch/papers/dp/dp1305.pdf

Economie de la santé / Health Economics

(2013). Les comptes de la Sécurité sociale. Résultats 2012 - Prévisions 2013 : Paris : Commission des comptes de la Sécurité sociale.
Abstract: Le rapport préparé pour la Commission de juin 2013 présente les comptes de 2012 et les prévisions pour 2013, pour le régime général de la Sécurité sociale et le fonds de solidarité vieillesse. Le déficit de l'ensemble régime général – fonds de solidarité vieillesse (FSV) s'est établi à -17,5 Md€ en 2012, soit une diminution de 10,5 Md€ par rapport au niveau de 2010 qui a marqué un maximum historique. Le déficit de 2012 reste toutefois très élevé par rapport aux niveaux observés en 2007-2008. La réduction des déficits amorcée en 2011 et 2012 marquerait le pas en 2013. Elle est rendue plus difficile par la dégradation de la conjoncture qui se traduit par un ralentissement de la masse salariale. Ce rapport contient également des fiches éclairage sur les problématiques suivantes : Environnement économique, Économies sur les dépenses de médicaments en ville, Bilan des dispositifs médicaux en ville, Médicaments de la « liste en sus » ; Dépenses d'invalidité, Bénéficiaires du Complément de libre choix d'activité (CLCA) ; Aides à la personne ciblées sur les publics fragiles ; État des lieux de la protection sociale complémentaire d'entreprise.
http://www.securite-sociale.fr/IMG/pdf/ccss_juin_2013__6-06_def.pdf

(2013). Analyse médicalisée des dépenses de santé : éclairages sur la répartition des dépenses et les leviers d'amélioration pour le système de santé : Paris : CNAMTS

Abstract: La France, par rapport aux autres pays de l'OCDE, enregistre depuis plusieurs années une progression plus maîtrisée de ses dépenses de santé. Depuis 2010, l'objectif national des dépenses d'assurance maladie (ONDAM) est respecté, témoignant des efforts collectifs importants engagés pour maîtriser leur croissance et assurer la soutenabilité financière du système. Cette maîtrise de l'évolution des dépenses ne dispense toutefois pas d'analyser leur nature et leurs finalités : en effet, en 2013, les dépenses relevant de l'ONDAM représentent 175 mds €. Pour mieux appréhender l'usage fait de ces ressources importantes consacrées au système de santé, l'Assurance Maladie a développé une nouvelle approche permettant d'analyser la dépense non seulement par type de soins (médicaux, infirmiers, médicaments, hospitalisation), comme cela est fait traditionnellement, mais par pathologie et processus de soins : Quels sont les problèmes de santé pris en charge ? Combien de personnes sont traitées pour ces pathologies ? La croissance des dépenses est-elle liée au nombre de personnes traitées ou à des évolutions de coûts de traitements ? Quelle part est induite par les facteurs démographiques ? Plusieurs points-clés ressortent de cette analyse et sont détaillés dans le rapport annuel sur l'évolution des charges et des produits de l'assurance maladie au titre de l'année 2014. Ce dossier de presse en fait la synthèse.
http://www.ameli.fr/fileadmin/user_upload/documents/23102013_DP_Analyse_medicalisee_des_depenses.pdf

Luengo-Fernandez R. (2013). Economic burden of cancer across the European Union: a population-based cost analysis. *The Lancet Oncology* (on line)

Abstract: Background In 2008, 2.45 million people were diagnosed with cancer and 1.23 million died because of cancer in the 27 countries of the European Union (EU). We aimed to estimate the economic burden of cancer in the EU. Methods In a population-based cost analysis, we evaluated the cost of all cancers and also those associated with breast, colorectal, lung, and prostate cancers. We obtained country-specific aggregate data for morbidity, mortality, and health-care resource use from international and national sources. We estimated health-care costs from expenditure on care in the primary, outpatient, emergency, and inpatient settings, and also drugs. Additionally, we estimated the costs of unpaid care provided by relatives or friends of patients (ie, informal care), lost earnings after premature death, and costs associated with individuals who temporarily or permanently left employment because of illness. Findings Cancer cost the EU €126 billion in 2009, with health care accounting for €51.0 billion (40%). Across the EU, the health-care costs of cancer were equivalent to €102 per citizen, but varied substantially from €16 per person in Bulgaria to €184 per person in Luxembourg. Productivity losses because of early death cost €42.6 billion and lost working days €943 billion. Informal care cost €23.2 billion. Lung cancer had the highest economic cost (€18.8 billion, 15% of overall cancer costs), followed by breast cancer (€15.0 billion, 12%), colorectal cancer (€13.1 billion, 10%), and prostate cancer (€8.43 billion, 7%). Interpretation Our results show wide differences between countries, the reasons for which need further investigation. These data contribute to public health and policy intelligence, which is required to deliver affordable cancer care systems and inform effective public research funds allocation.
http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(13)70442-X/abstract

Lyman G.H. (2013). Counting the costs of cancer care. *The Lancet Oncology* (on line)

http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(13)70480-7/fulltext

Ades F. (2013). Discrepancies in cancer incidence and mortality and its relationship to health expenditure in the 27 European Union member states. *Annals of Oncology* (on line)

Abstract: Background: The European Union (EU) is a confederation of 27 member states, the institutions of which work according to negotiated decisions. The EU has implemented similar legislation and a common market, and has adopted the same currency in most of its member states. Although financing health systems is a responsibility of the national governments, the EU has enacted the Charter of Fundamental Rights to standardize public health policies. However, for historical reasons, health policy and health expenditure is not uniform across the 27 EU member states (EU-27). Material and methods: We hypothesized that increased health expenditure would be associated with better cancer outcome and that this would be most apparent in breast cancer, because of the availability of effective screening methods and treatments. Using publically available data from the World Health Organization, the International Monetary Fund, and the World Bank, we assessed associations between cancer indicators and wealth and health indicators. To do so, we constructed scatter plots and used the Spearman's rank correlation coefficient. Results: A marked difference in

wealth and health expenditure indicators was observed between Eastern and Western European countries, with Western European being the higher. Higher wealth and higher health expenditures were associated both with increased cancer incidence and decreased cancer mortality. In breast cancer, the association with incidence was stronger. We created mortality/incidence ratios and observed that the more spent on health, the fewer the deaths after a cancer diagnosis. Conclusion: Despite the initiatives to standardize public health policies of the EU-27, health expenditure continues to be higher in Western European countries and this is associated with better cancer outcome in these countries.

Etat de santé / Health Status

(2013). Rapport national 2013 (données 2012) à l'OEDT par le point focal français du réseau Reitox France. Nouveaux développements, tendances et information détaillée sur des thèmes spécifiques : Saint Denis : OFD.

Abstract: Chaque année, à l'instar de l'ensemble des "points focaux" en Europe, l'OFDT adresse à l'Observatoire européen des drogues et des toxicomanies un rapport national dressant l'état du phénomène de la drogue dans le pays. C'est à partir de l'ensemble de ces rapports nationaux que l'agence de l'Union européenne rédige l'année suivante son Rapport européen sur les drogues.Le rapport national français 2013 (données 2012) est composé, comme ses homologues, de dix chapitres : politique publique, mesure des usages, prévention, usages problématiques, prises en charge, conséquences sanitaires, réponses aux problèmes sanitaires, conséquences sociales, criminalité et marchés.
http://www.ofdt.fr/BDD/publications/docs/efnxoftb.pdf

(2013). Cancer Care. Assuring Quality to Improve Survival : Paris : OCDE.

Abstract: Cancer remains a major health care challenge in OECD countries and the financial burden associated with cancer is also growing. However, despite recent improvements in cancer treatment and prevention, countries are not doing as well as they could to fight the disease: an estimated one-third of cases could be cured if detected on time and adequately treated, and another one-third could be prevented entirely if more far-reaching public health measures were in place. Furthermore, cancer survival data show almost a four-fold difference across OECD countries. While some countries are lagging behind in cancer care performance, other countries have designed systems that make them global leaders in the fight against cancer. This report aims to share best practice and improve cancer care performance across countries. Drawing on questionnaires and structured interviews conducted with cancer experts in 35 countries, it describes variations in the resources countries allocate to cancer care, care practices and governance systems for cancer care. It explores the policy trends in cancer care across countries over the past decade and identifies which policy approaches are associated with the best cancer survival. The report concludes by offering concrete recommendations for creating and supporting high-quality cancer care systems (résumé de l'éditeur).
http://www.oecd-ilibrary.org/fr/social-issues-migration-health/cancer-care_9789264181052-en

Le Clainche C., Tubeuf S. (2013). Nannying, nudging, rewarding? A discussion on the constraints and the degree of control over health status : Leeds : Leeds Institute of Health Sciences

Abstract: Public health policies typically assume that there are characteristics and constraints over health that an individual cannot control and that there are choices that an individual could change if he is nudged or provided with incentives. We consider that health is determined by a range of personal, social, economic and environmental factors and we discuss to what extent an individual can control those factors. In particular, we assume that observed health status is the result of individual control and constraints to change that an individual faces. We suggest three different constraints: budget, time and psychological constraints and position various determinants of health according to increasing levels of constraint and increasing degrees of individual control. We finally discuss public health policies such as nannying, nudging, and rewarding within this new framework and show that the level of constraints and the degree of individual control over health status are essential dimensions to

consider when designing and implementing public health policies.
http://ideas.repec.org/p/lee/wpaper/1306.html

Géographie de la santé / Geography of Health

Chevillard G., Mousques J., Lucas-Gabrielli V., Bourgueil Y., Rican S. (2013). Répartition géographique des maisons et pôles de santé en France et impact sur la densité des médecins généralistes libéraux. Deuxième volet de l'évaluation des maisons, pôles et centres de santé dans le cadre des expérimentations des nouveaux modes de rémunération (ENMR). *Questions d'Economie de la Santé (Irdes),* (190) :
Abstract: Les maisons de santé sont-elles implantées dans des espaces où l'offre de soins est fragile et les besoins importants ? Le développement de ces structures a-t-il eu un effet sur l'évolution de la densité de médecins généralistes ? Ce deuxième volet de l'évaluation des sites regroupés pluriprofessionnels participant aux expérimentations des nouveaux modes de rémunération (ENMR) traite ces deux questions concernant les maisons de santé recensées par l'Observatoire des recompositions de l'offre de soins. Il s'appuie sur deux typologies caractérisant les situations socio-économiques et sanitaires des espaces français, l'une sur des espaces à dominante rurale, l'autre sur des espaces à dominante urbaine. À partir des classes de bassins de vie et de pseudo-cantons ainsi définies, les densités de médecins généralistes y exerçant sont comparées sur deux périodes consécutives 2004-2008 et 2008-2011, selon que ces espaces abritent ou non une maison de santé.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/190-repartition-geographique-des-maisons-et-poles-de-sante-en-france-et-impact-sur-la-densite-des-medecins-generalistes-liberaux.pdf

Chevillard G., Mousques J., Lucas-Gabrielli V., Bourgueil Y., Rican S., Salem G. (2013). Maisons et pôles de santé : places et impacts dans les dynamiques territoriales d'offre de soins en France : Paris : IRDES
Abstract: Depuis une dizaine d'années, les pouvoirs publics encouragent le regroupement pluriprofessionnel en soins de premiers recours, notamment en direction des maisons et pôles de santé. Ces structures ont pour vocation première de maintenir ou renforcer l'offre de soins dans les espaces fragiles. Cette étude décrit les espaces dans lesquels sont implantés les maisons et pôles de santé, et analyse l'évolution de la densité de médecins généralistes dans ces espaces. Deux typologies ont été réalisées, qui distinguent les espaces à dominante urbaine et à dominante rurale, permettant une analyse spécifique de ceux-ci. Ces typologies décrivent les espaces d'implantation des maisons et pôles de santé selon les caractéristiques de la population, de l'offre de soins et de la structure spatiale de ceux-ci. Ces typologies permettent, dans un second temps, d'analyser l'évolution de la densité de médecins généralistes dans ces espaces, selon qu'ils abritent ou non des maisons et pôles de santé. Les premiers résultats montrent que ces structures sont majoritairement implantées dans des espaces à dominante rurale plus fragiles en termes d'offre de soins, ce qui suggère une logique d'implantation des maisons et pôles de santé qui répond à l'objectif de maintenir une offre là où les besoins sont importants. On observe une moindre diminution de la densité des médecins généralistes entre 2008 et 2011 dans ces espaces, comparés à ceux du même type mais sans maisons et pôles de santé. Dans les espaces à dominante urbaine, dans lesquels ces structures sont moins présentes, la logique d'implantation suggère également une logique de rééquilibrage de l'offre de soins de premiers recours en faveur des espaces périurbains moins dotés. En outre, on constate une évolution plus favorable de la densité de médecins généralistes.
http://www.irdes.fr/recherche/documents-de-travail/057-maisons-et-poles-de-sante-places-et-impacts-dans-les-dynamiques-territoriales-d-offre-de-soins-en-france.pdf

Delga C. 2013). Mission pour l'amélioration de la qualité et de l'accessibilité des services au public dans les territoires fragiles : Paris : La Documentation française.
Abstract: Bouleversement des rapports entre les citoyens et les services publics induits notamment par les nouvelles technologies, réorganisation de nombreux services publics sur fond de raréfaction de la ressource publique, ou encore fermeture de services marchands, tous ces phénomènes ont accentué les inégalités territoriales dans de nombreux territoires déjà fragiles. Alors que des initiatives publiques et privées se sont mises en place pour garantir l'offre de services aux habitants des zones

fragiles, la présente mission a pour objet d'apporter sa contribution à ce mouvement de réorganisation en identifiant et améliorant les dispositifs jugés les plus efficaces. Après avoir procédé à un état des lieux de l'offre de services au public, la mission propose une série de recommandations visant à améliorer, renforcer, inventer les moyens à disposition des pouvoirs publics pour garantir l'accessibilité et la qualité des services au public dans les territoires sensibles (résumé d'auteur).
http://www.ladocumentationfrancaise.fr/var/storage/rapports-publics/134000678/0000.pdf

Hôpital / Hospitals

Couty E. (2013). Financer l'hôpital, le professionnel ou le parcours du patient ? In : Rémunérer les services de santé. *Sève : les Tribunes de la Santé* (40) :

Abstract: Le mode de financement de notre système de soin s'est construit selon le mode d'exercice du professionnel concerné et non selon le malade pris en charge. Cette dépendance du mode de financement va marquer profondément toutes les réformes du financement des secteurs hospitaliers public et privé jusqu'à la mise en place de la tarification à l'activité (T2A). Le modèle T2A adopté en France a cependant montré des limites, pointées par les utilisateurs eux-mêmes. Après une analyse critique des différents modes de financement de l'hôpital, l'article pose trois interrogations – doit-on maintenir un lien étroit entre description de l'activité médicale et tarif? Doit-on conserver un modèle unique de tarification?? doit-on, dans le cadre d'une médecine de parcours, maintenir une stricte séparation entre financement de la médecine ambulatoire et financement de l'hôpital? – et propose quelques pistes de réflexion pour contribuer aux évolutions nécessaires (Résumé de l'éditeur).

Coriat P. (2013). Les hôpitaux face à la contrainte de la démographie des anesthésistes-réanimateurs. In : Rémunérer les services de santé. *Sève : les Tribunes de la Santé* (40):

Abstract: Les contraintes démographiques auraient dû être un moteur de la modernisation de l'offre de soins et favoriser les restructurations hospitalières pour une meilleure efficience du circuit patient, garant de la qualité des soins. Mais face à ces contraintes, les hôpitaux publics ont gardé une organisation centrée sur le système de soins et sa régulation et maintenu leurs activités médicochirurgicales malgré un manque évident de médecins compétents. Les contraintes démographiques ont paradoxalement renforcé la gestion «notariale» des structures hospitalières et les «patriotismes de sites?», avec pour seul but de maintenir une offre de soins chirurgicale dans le plus grand nombre d'établissements de santé possible. Cette démarche a conduit à augmenter le recours aux médecins hors UE dans le cadre de la nouvelle procédure d'autorisation d'exercice, à développer l'activité des médecins anesthésistes-réanimateurs sur plusieurs sites, et surtout à recourir massivement à l'intérim, avec pour conséquence une diminution de la qualité des soins et une dépense qui n'est plus maîtrisée (résumé de l'éditeur).

(2013). Rapport 2013 au Parlement sur le financement des établissements de santé :

Paris : MSSPS.

Abstract: Comme chaque année, le gouvernement présente au Parlement, avant le 15 septembre de chaque année, un rapport sur les actions menées sur le champ du financement des établissements de santé incluant un bilan rétrospectif et présentant les évolutions envisagées. On retrouvera dans ce document, les trois chapitres portant sur les conditions de réalisation de l'exercice 2012 qui ont servi au cadrage de la campagne 2013, les principales évolutions apportées au modèle de financement en 2013 et les perspectives d'évolution des modèles de financement des établissements de santé. Le nombre global de séjours, dont plus de 26 % sont des séances, a augmenté de + 1,8 % entre 2011 et 2012. Parallèlement, le volume économique a plus progressé dans le secteur Ex DG (+ 3,1 %) que dans le secteur Ex OQN (+ 1 %), ceci à classification constante. La durée moyenne des séjours enregistre une diminution, notamment en chirurgie non ambulatoire. En 2012, la croissance de l'activité de HAD s'est poursuivie mais de manière moins dynamique que les années précédentes. Les dotations servant à financer les missions d'intérêt général et d'aide à la contractualisation - MIGAC - ont augmenté en 2012 de 3,44 %, près de 7 % de ces dotations finançant les MIG. Enfin, l'évolution récente de la situation financière des établissements de santé ressort comme globalement encourageante avec des comptes d'établissements de santé ex DG qui seraient revus à l'équilibre,

avec un résultat excédentaire d'environ 100 millions d'euros et une capacité d'autofinancement revenue à son meilleur niveau (4,6 Md d'euros).
http://www.apmnews.com/documents/2013_financement_etablissements_sante.pdf

(2013). Hospitals and borders. Seven case studies on cross-border collaboration and health system interactions. Observatory Studies Series ; 31. Copenhague : OMS Bureau régional de l'Europe //
Abstract: The European Union (EU) Directive on the application of patients' rights in cross-border health care explicitly calls for Member States to cooperate in crossborder health care provision in border regions. Given that most cross-border collaboration in the health care field involves secondary care, the legal text places hospitals close to national frontiers at the centre of attention. But how do hospitals interact with each other and with other health care actors across borders? Why does cross-border collaboration take place? Who actually benefits from it? And when does it work? These are the questions at the heart of the present volume. Seven case studies examine the circumstances under which cross-border collaboration is likely to work; the motivations and incentives of health care actors;and the role played by health systems, individuals and the EU in shaping crossborder collaboration. The study is original in that it produces qualitative and analytical scientific evidence on aspects of cross-border collaboration involving hospitals from a geographically diverse selection of cases covering 11 EU and non-EU countries (Austria, Belgium, Bulgaria, Denmark, Finland, France, Germany, the Netherlands, Norway, Romania, and Spain). This book is of interest to decision-makers and field actors engaged in or considering cross-border collaboration. Questions on feasibility, desirability and implementation are at the core of the analysis. The book puts forward policy conclusions directly linked to the EU Directive on patients' rights and proposes a "toolbox" of prerequisites necessary to start or maintain cross-border collaboration in health care. In addition to its deliberate policy perspective, it is relevant to observers and students of the intersection between the EU and domestic health systems known as cross-border health care.
http://www.euro.who.int/__data/assets/pdf_file/0019/233515/Hospitals-and-Borders.pdf

Blomqvist A. 2013). Paying Hospital-Based Doctors: Fee for Whose Service ? Toronto : CD Howe Institute //.
Abstract: Canadian specialist doctors are paid mainly through fee-for-service for the procedures they perform. Nationwide, more than 80 percent of surgical specialists' income comes from fee-for-service payments that are negotiated collectively with provincial health ministries. Surgical specialists make up about 20 percent of all full-time equivalent physicians, and fee-for-service payments to them accounted for close to $4 billion nationwide in 2011/12. Because physicians' decisions are the major drivers for most healthcare costs, getting the incentives right regarding the way doctors are paid is critical in ensuring Canadians receive good value for money from the healthcare system. Whereas most hospital-based specialist doctors are paid via fee-for-service by provincial insurance plans, most hospital funding comes through a separate pipe, in the form of lump-sum amounts not linked to the number and quality of services provided. The result is a system in which neither specialists' time nor hospital resources are efficiently used, contributing to high costs and long waiting lists. One contributing factor to waiting lists, and one reason why many recently graduated specialists in Canada are unemployed or underemployed, is a lack of complementary facilities, such as operating rooms, and the lack of complementary professionals, such as anaesthesiologists, nurses and so on. When a medical procedure requires hospital facilities as well as specialist time, the fee should be shared between hospitals and specialists in ways that give both a stake in producing high-quality care at low costs. We propose that hospital-based physicians be paid directly from hospital budgets as opposed to the current practice of paying them separately through provincial insurance plans. Hospitals would then engage doctors and pay them appropriately – either by salary, fee-for-service, or a blend of methods. This would result in stronger incentives for providers to better deploy resources but may also lead to potential side effects, such as cost shifting and lower quality of care. In this Commentary, we discuss how incentives to both hospitals and doctors could be carefully designed to avoid pitfalls and to promote more efficient use of resources.
http://www.cdhowe.org/pdf/Commentary_392.pdf

Lance J.M.R. 2013). Le financement axé sur les patients. Revue de littérature sur les expériences étrangères : Québec : INESS.
Abstract: Cette note informative se penche sur les expériences menées à l'étranger pour remplacer la budgétisation globale des établissements par le financement à l'acte. Elle a pour objectifs d'examiner

ces expériences, de les décrire, de préciser les étapes de leur élaboration et de leur implantation, de déterminer les préalables et les conditions nécessaires à leur mise en œuvre et de souligner les obstacles à surmonter et les erreurs à éviter, en vue d'en arriver à une implantation réussie au Québec.
http://www.inesss.qc.ca/fileadmin/doc/INESSS/Rapports/EtudeEconomique/INESSS_Financement_axe_patients.pdf

Guccio C. (2013). Readmission and Hospital Quality under Prospective Payment System : Catania : University of Catania

Abstract: Nowadays different healthcare policies in OECD countries seem to consider hospital readmission somehow "quality dependent". Nonetheless, the theoretical literature on the incentives provided by payment systems tend to disregard this aspect, which indeed might be relevant in driving providers' behaviour. In this paper we study the incentives for hospitals to provide quality and cost-reducing effort under different payment regimes, either a global budgeting or a prospective payment system, considering explicitly the role played by financial incentives directly linked to readmission. As far as the specific results about quality are concerned, we find that prospective payment systems do not necessarily perform better than retrospective systems if the reimbursement to hospitals is not adjusted to take into account specific outcome-based indicators of quality, such as readmission. More specifically, if patients readmitted are fully paid to hospitals, moving from a retrospective to a prospective payment systems might even induce a reduction on quality and, in turn, an increase in readmission probability. However, if the prospective payment system is adjusted for internalizing this counter-incentive, by a different payment for patients readmitted, it could be able to foster a higher treatment quality through the competition channel.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2350689

Informatique médicale / Medical Informatics

(2013). ICTs and the Health Sector. Towards Smarter Health and Wellness Models : Paris : OCDE.

Abstract: This report examines the challenges facing health care systems and the strategic directions for a smarter health and wellness future, from both technological and policy viewpoints. It looks at the role of information and communication technologies (ICTs) and discusses the research and policy options that could further the development of smarter health and wellness systems.
http://www.oecd-ilibrary.org/fr/science-and-technology/icts-and-the-health-sector_9789264202863-en

Méthodologie – Statistique / Methodology – Statistics

Lichtenberg F.R. (2013). The Impact of Biomedical Knowledge Accumulation on Mortality: A Bibliometric Analysis of Cancer Data : Cambridge : NBER

Abstract: I examine the relationship across diseases between the long-run growth in the number of publications about a disease and the change in the age-adjusted mortality rate from the disease. The diseases analyzed are almost all the different forms of cancer, i.e. cancer at different sites in the body (lung, colon, breast, etc.). Time-series data on the number of publications pertaining to each cancer site were obtained from PubMed. For articles published since 1975, it is possible to distinguish between publications indicating and not indicating any research funding support. My estimates indicate that mortality rates: (1) are unrelated to the (current or lagged) stock of publications that had not received research funding; (2) are only weakly inversely related to the contemporaneous stock of published articles that received research funding; and (3) are strongly inversely related to the stock of articles that had received research funding and been published 5 and 10 years earlier. The effect after 10 years is 66% larger than the contemporaneous effect. The strong inverse correlation between mortality growth and growth in the lagged number of publications that were supported by research

funding is not driven by a small number of outliers.
http://www.nber.org/papers/w19593

(2012). Multilevel modeling techniques and applications in institutional research. New directions for institutional research ; 154. San Francisco : John Wiley & Sons/
Abstract: Multilevel modeling is an increasingly popular multivariate technique that is widely applied in the social sciences. Increasingly, practitioners are making instructional decisions based on results from their multivariate analyses, which often come from nested data that lend themselves to multilevel modeling techniques. As data-driven decision making becomes more critical to colleges and universities, multilevel modeling is a tool that will lead to more efficient estimates and enhance understanding of complex relationships. This volume illustrates both the theoretical underpinnings and practical applications of multilevel modeling in IR. It introduces the fundamental concepts of multilevel modeling techniques in a conceptual and technical manner. Providing a range of examples of nested models that are based on linear and categorical outcomes, it then offers important suggestions about presenting results of multilevel models through charts and graphs (4e de couverture).
http://eu.wiley.com/WileyCDA/WileyTitle/productCd-1118444000.html

Gelman A. (2013). Why ask Why? Forward Causal Inference and Reverse Causal Questions : Cambridge : NBER
Abstract: The statistical and econometrics literature on causality is more focused on "effects of causes" than on "causes of effects." That is, in the standard approach it is natural to study the effect of a treatment, but it is not in general possible to define the causes of any particular outcome. This has led some researchers to dismiss the search for causes as "cocktail party chatter" that is outside the realm of science. We argue here that the search for causes can be understood within traditional statistical frameworks as a part of model checking and hypothesis generation. We argue that it can make sense to ask questions about the causes of effects, but the answers to these questions will be in terms of effects of causes.
http://www.nber.org/papers/w19614

Jones C.W. (2013). Non-publication of large randomized clinical trials: cross sectional analysis. *British Medical Journal,* 347
Abstract: Objective : To estimate the frequency with which results of large randomized clinical trials registered with ClinicalTrials.gov are not available to the public. Design Cross sectional analysis Setting Trials with at least 500 participants that were prospectively registered with ClinicalTrials.gov and completed prior to January 2009. Data sources PubMed, Google Scholar, and Embase were searched to identify published manuscripts containing trial results. The final literature search occurred in November 2012. Registry entries for unpublished trials were reviewed to determine whether results for these studies were available in the ClinicalTrials.gov results database. Main outcome measures The frequency of non-publication of trial results and, among unpublished studies, the frequency with which results are unavailable in the ClinicalTrials.gov database. Results Of 585 registered trials, 171 (29%) remained unpublished. These 171 unpublished trials had an estimated total enrollment of 299 763 study participants. The median time between study completion and the final literature search was 60 months for unpublished trials. Non-publication was more common among trials that received industry funding (150/468, 32%) than those that did not (21/117, 18%), P=0.003. Of the 171 unpublished trials, 133 (78%) had no results available in ClinicalTrials.gov. Conclusions Among this group of large clinical trials, non-publication of results was common and the availability of results in the ClinicalTrials.gov database was limited. A substantial number of study participants were exposed to the risks of trial participation without the societal benefits that accompany the dissemination of trial results.
http://www.bmj.com/content/347/bmj.f6104

Benoit F. 2013). Les théories de politiques publiques et leur utilité en santé publique : le modèle des étapes : Montréal : C.C.N.P.P.S.
Abstract: Ce document présente un modèle développé en sciences politiques et qui permet d'illustrer le cheminement des politiques publiques. La présente note documentaire fait partie d'une série de courtes notes sur les différents modèles utilisés en sciences politiques pour représenter les processus de développement des politiques publiques. Dans ce document, nous nous attardons au modèle des étapes, un modèle qui permet de présenter de manière relativement simple le cheminement complexe

des politiques publiques.
http://www.ccnpps.ca/docs/ModeleEtapesPolPubliques_FR.pdf

Médicaments / Pharmaceuticals

Johanet G. (2013). La politique de fixation des prix du médicament. In : Rémunérer les services de santé. *Sève : les Tribunes de la Santé* (40)
Abstract: Le médicament remboursable représente une part importante des dépenses d'assurance maladie et de leur croissance. Son prix, fixé par le CEPS, tient compte su service médical rendu, évalué par la HAS, et des prix pratiqués dans les principaux pays de l'UE. Après les décennies 1970-2000 dominées par les blockbusters, le modèle actuel (produits à coûts unitaires élevés pour des populations restreintes) entraîne une recomposition du marché. Il apparaît que ce n'est pas tant le prix des médicaments que le coût global de la prescription qui est élevé, les médecins français prescrivant largement les médicaments les plus chers. Quelques contradictions dans la fixation des prix du médicament sont ici soulignées, de même que certaines failles dans la détermination des pouvoirs publics à y remédier (Résumé de l'éditeur).

Przyswa E. G. (2013). Contrefaçon de médicaments sur Internet : prévenir une menace réelle sur la santé publique. *Sève : les Tribunes de la Santé* (40)
Abstract: Cet article aborde l'impact d'Internet sur les trafics de médicaments contrefaits et démontre l'importance d'une analyse plus rigoureuse et mieux cadrée d'une réalité trop souvent perçue sous un angle anxiogène ou simplificateur. Dans un tel contexte il est essentiel de développer des logiques coopératives, notamment en termes de normes et d'implication des consommateurs, car les approches répressives classiques se révèleront de moins en moins pertinentes (Résumé de l'éditeur).

Verger P. (2010). Drug reimbursement and GPs' prescribing decisions : a randomized case-vignette study about the pharmacotherapy of obesity associated with type 2 diabetes: how GPs react to drug reimbursement. *Fundamental & Clinical Pharmacology,* 24 (4) :
Abstract: This study sought to identify the effect of drug reimbursability - a decision made in France by the National Authority for Health - on physicians' prescribing practices for a diet drug such as rimonabant, approved for obese or overweight patients with type-2 diabetes. A cross-sectional survey of French general practitioners (GPs) presented a case-vignette about a patient for whom this drug is indicated in two alternative versions, differing only in its reimbursability, to two separate randomized subsamples of GPs in early 2007, before any decision was made about reimbursement. The results indicate that (i) more than 20% of GPs in private practice would be willing to prescribe a non-reimbursed diet drug for patients with obesity complicated by type 2 diabetes; (ii) the number of GPs willing to prescribe it would increase by 47.6% if the drug were reimbursed, and (iii) such a drug would be adopted at a higher rate by GPs who have regular contacts with pharmaceutical sales representatives. In France, unlike most other countries, drug reimbursement status is a signal of quality. However, our results suggest that a significant proportion of GPs would spontaneously adopt anti-obesity drugs even if they were not reimbursed. Decisions about reimbursement of pharmaceutical products should be made taking into account that reimbursement is likely to intensify prescription.

Duguet E. L. (2012). Does Patenting Increase the Private Incentives to Innovate? A Microeconometric Analysis. *Annales d'Economie et de Statistique,* (107-108) :
Abstract: The role played by the patent system as an innovation incentive is at the center of an important current debate. The relevance of the patent system for the development of high-tech industries has been put into question. This paper adds to the prior evidence by looking at the relationship between patent rights and innovation performance in French manufacturing over the period 1997-1999. In order to sort problems of endogeneity out, we use a structural model of research, innovation and patenting. In particular, since the type of innovation (product, process) may drive appropriability conditions, the model takes this dimension into account. The empirical results are clear-

cut: patents significantly promote product innovations but not process innovations. Similarly, the patent premium increases with the value of product innovations but is not directly affected by the value of process innovations.

Mccabe C. (2013). Leasing health technologies- an affordable and effective reimbursement strategy for innovative technologies? Leeds : Leeds Institute of Health Sciences

Abstract: The challenge of implementing high cost innovative technologies in health care systems operating under significant budgetary pressure has seen a radical shift in the health technology reimbursement landscape. New reimbursement strategies attempt to reduce the risk of making the wrong decision; i.e. paying for a technology that is not good value for the health care system, whilst promoting the adoption of innovative technologies into clinical practice. However, the remaining risk is not shared between the manufacturer and the health care payer at the individual purchase level; it continues to be passed from the manufacturer to the payer at the time of purchase. In this paper we propose a health technology payment strategy – Technology Leasing Reimbursement Scheme (TLRS) - which allows the sharing of risk between the manufacturer and the payer; the replacing of upfront payments with a stream of payments spread over the ex pected duration benefit from the technology, subject to the technology delivering the claimed health benefit. Using trastuzumab (Herceptin) in Early Breast Cancer as an exemplar technology we show how a TLRS not only reduces the total budgetary impact of the innovative technology, it also truly shares risk between the manufacturer and the health care system, whilst reducing the value of further research and thus promoting the rapid adoption of innovative technologies into clinical practiceolicies.
http://ideas.repec.org/p/lee/wpaper/1302.html

Datta A. (2013). Effects of Physician-Directed Pharmaceutical Promotion on Prescription Behaviors: Longitudinal Evidence : Cambridge : NBER

Abstract: Spending on prescription drugs (Rx) represents one of the fastest growing components of U.S. healthcare spending, and has coincided with an expansion of pharmaceutical promotional spending. Most (83%) of Rx promotion is directed at physicians in the form of visits by pharmaceutical representatives (known as detailing) and drug samples provided to physicians' offices. Such promotion has come under increased public scrutiny, with critics contending that physician-directed promotion may play a role in raising healthcare costs and may unduly affect physicians' prescribing habits towards more expensive, and possibly less cost-effective, drugs. In this study, we bring longitudinal evidence to bear upon the question of how detailing impacts physicians' prescribing behaviors. Specifically, we examine prescriptions and promotion for a particular drug class based on a nationally-representative sample of 150,000 physicians spanning 24 months. The use of longitudinal physician-level data allows us to tackle some of the empirical concerns in the extant literature, virtually all of which has relied on aggregate national data. We estimate fixed-effects specifications that bypass stable unobserved physician-specific heterogeneity and address potential targeting bias. In addition, we also assess differential effects at both the extensive and intensive margins of prescribing behaviors, and differential effects across physician- and market-level characteristics, questions which have not been explored in prior work. The estimates suggest that detailing has a significant and positive effect on the number of new scripts written for the detailed drug, with an elasticity magnitude of 0.06. This effect is substantially smaller than those in the literature based on aggregate information, suggesting that most of the observed relationship between physician-directed promotion and drug sales is driven by selection bias. Qualitatively consistent with the literature, we find that detailing impacts selective brand-specific demand but does not have any substantial effects on class-level demand. Results also indicate that most of the detailing response may operate at the extensive margin; detailing affects the probability of prescribing the drug more than it affects the number of prescriptions conditional on any prescribing. We draw some implications from these estimates with respect to effects on healthcare costs and public health.
http://www.nber.org/papers/w19591

Lemmens T. (2013). The Case for Improved Post-Market Surveillance of Pharmaceuticals : Toronto : University of Toronto

Abstract: In Canada, as in other countries, drug approval is predominantly focused on assessing safety and efficacy at market-entry, based on pre-market clinical trials data. In this paper, we discuss how the fixation of the drug approval system on pre-market activities results in a host of serious issues including: 1) a lack of good evidence on drug safety when assessments are based solely on data

produced in clinical trials; 2) a lack of comparative evidence on patient benefit between different drugs; 3) problems with lack of data about off-label prescription, which is directly associated with these two above problems; and 4) an inadequate reporting of adverse drug reactions (ADRs). In this memorandum, prepared for a presentation at an expert witness hearing of the Canadian Standing Senate Committee on Social Affairs, Science and Technology for its study of Prescription Pharmaceuticals in Canada, we argue that improving and expanding post-market surveillance is a critical to address these issues. In particular, we highlight that drug regulatory reforms should include a more explicit requirement for both comparative effectiveness studies and for post-market clinical research on the effects of drugs in real-world settings. Further, we advocate for improvements to the current ADR reporting system, as well as for improvements in the systems for collecting, storing and analyzing ADR data. Finally, the memorandum concludes with a brief discussion of Health Canada's recent reform proposals to adopt a progressive licensing framework, which while offering important reforms such as the ability to compel drug manufacturers to conduct post-market studies, nonetheless fall short in certain respects.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2341992

Politique de santé / Health Policy

(2013). Good governance for prison health in the 21st century. A policy brief on the organization of prison health : Copenhague : OMS Bureau régional de l'Europe.

Abstract: Ce rapport publié par le Bureau régional de l'OMS pour l'Europe est un document de synthèse sur la gouvernance de la santé carcérale au 21e siècle. Rédigé par les membres du réseau « Santé et prison » de l'OMS, associés à un groupe d'experts, ce document présente un ensemble d'analyses et de recommandations pour promouvoir une bonne gouvernance de la santé carcérale. Une première partie, qui apporte des indicateurs sur l'incarcération et la santé carcérale en Europe, explique pourquoi la santé carcérale doit être considérée comme une partie intégrante de la santé publique. Une seconde partie présente les aspects législatifs du droit à la santé des personnes incarcérées, tandis qu'une troisième partie analyse les lacunes des dispositions actuelles. Enfin, une quatrième partie est consacrée aux principes et aux recommandations pour une bonne gouvernance de la santé carcérale.
http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf

Hansen J. (2013). Strengthening the European Dimension of Health Services Research. *POLICY BRIEF,*

Abstract: In order for Health Services Research (HSR) to help address Europe's health care challenges, we need to improve the production and uptake of HSR insights into European and national policies. For this, we need a much closer collaboration and sharing of insights, not only between Member States, but also between funding bodies, research disciplines, as well as the research community with policy makers and practitioners. Only then can we come to a more balanced and less defragmented European health research agenda. In a nutshell, we mostly need : a broader research chain from research lab to real-life implementation; to use Europe as a natural laboratory for health services and systems research; to move from centres of excellence to a sector of excellence; to synchronize national and European research agendas; to better monitor the societal impact of health services research. better training in transferring knowledge in order to realise more evidence informed policies and capacity building in countries with less HSR potential (résumé éditeur).
http://www.healthservicesresearch.eu/mediaFiles/upload/HSR_Europe_Policy_Brief_2013_Strengthening_the_Eur_dimension_of_HSR.pdf

Prévention / Prevention

Dreux C. 2013). La Culture de prévention en santé : des questions fondamentales : Paris : Académie nationale de médecine.
Abstract: Ce rapport a essentiellement pour but d'alerter les pouvoirs publics décisionnels sur les moyens à mettre en œuvre pour développer, en France, une véritable culture de prévention dans le domaine de la santé. Compte tenu de l'étendue du sujet, il a été décidé de traiter quelques questions fondamentales de la prévention sanitaire puis d'aborder plus particulièrement les questions relatives à certaines catégories spécifiques. Après une introduction "la prévention en médecine est un humanisme", ce rapport aborde les sujets suivants : Définition de la culture de prévention; Pourquoi et comment développer une culture de prévention en santé publique ?; prévention et inégalités sociales de santé; prévention et économie de la santé; éducation du public : Apport des procédures informatisées (TICS); l'importance majeure de la famille, de l'école et de la médecine scolaire; peut-on, à la naissance, prévoir les maladies de l'âge adulte ?; pour une prévention fondée sur les preuves.
http://www.academie-medecine.fr/articles-du-bulletin/publication/?idpublication=100189

Prévision – Evaluation / Prevision – Evaluation

Hamel M.B. (2013). Analyse des big data. Quels usages, quels défis ? *Note d'Analyse (La),* (8) :
Abstract: La multiplication croissante des données produites et le développement d'outils informatiques permettant de les analyser offre d'innombrables possibilités tant pour l'État que pour les entreprises. Il ne fait aucun doute que le traitement de ces masses de données, ou big data, jouera un rôle primordial dans la société de demain, car il trouve des applications dans des domaines aussi variés que les sciences, le marketing, les services client, le développement durable, les transports, la santé, ou encore l'éducation. Par ailleurs, le potentiel économique de ce secteur est indéniable et les retombées en termes d'emploi et de création de richesse seront non négligeables. Son développement nécessite toutefois de bien comprendre les enjeux qui y sont liés. C'est l'objectif de cette note, qui s'attache à détailler ce qu'est l'analyse des big data et présente les usages possibles de ces technologies, qu'il s'agisse de rendre la gestion plus efficace, d'améliorer les services rendus ou de prévenir des phénomènes nuisibles (épidémies, criminalité, etc.). Elle expose les principales difficultés associées à ces usages : garantir la confidentialité et le respect de la vie privée. Enfin, elle montre comment différents pays et entreprises ont d'ores et déjà investi dans ce secteur (résumé d'auteur).
http://www.strategie.gouv.fr/blog/wp-content/uploads/2013/11/2013-11-09-Bigdata-NA008.pdf

Soins de santé primaires / Primary Health Care

Afrite A., Bourgueil Y., Daniel F., Mousques J. (2013). L'impact du regroupement pluriprofessionnel sur l'offre de soins. Objectifs et méthode d'une évaluation des maisons, pôles et centres de santé dans le cadre de l'expérimentation des nouveaux modes de rémunération. *Questions d'Economie de la Santé (Irdes),* (189) :
Abstract: La pratique en groupe monodisciplinaire des médecins généralistes, attractive pour les jeunes, est désormais majoritaire. Depuis une dizaine d'années, les pouvoirs publics encouragent le regroupement pluriprofessionnel en soins de premiers recours, principalement en direction des maisons, pôles et centres de santé. Dans ce cadre, les expérimentations de nouveaux modes de rémunération (ENMR) à destination de ces structures ont été mises en œuvre en 2010. Il s'agit de financer l'amélioration de l'organisation et de la coordination des soins, de proposer de nouveaux services aux patients et de développer la coopération interprofessionnelle. À partir de l'observation des sites recensés dans l'Observatoire des recompositions de l'offre de soins ou participant aux ENMR, cet article présente les objectifs et la méthode générale d'une évaluation de ces formes de regroupement, dont la connaissance reste encore parcellaire. Deux questions principales sont posées : l'exercice collectif interprofessionnel permet-il de maintenir une offre de soins dans les zones moins

bien dotées ? Est-il plus performant en termes d'activité et de productivité, de consommation et de qualité des soins ? Premier volet de cadrage méthodologique, ce Questions d'économie de la santé inaugure une série de publications de résultats.
http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/189-l-impact-du-regroupement-pluriprofessionnel-sur-l-offre-de-soins.pdf

Bourgueil Y. (2013). La mutation des modes de paiement des professionnels en soins primaires au Canada et en France. In : Rémunérer les services de santé. *Sève : les Tribunes de la Santé* (40)
Abstract: Cet article fait état des évolutions en cours dans les modes de rémunération dans le domaine des soins primaires en comparant le Canada et la France, deux pays qui présentent des systèmes de santé proches et qui s'influencent depuis de nombreuses années. La description des modes innovants de paiement des médecins, leurs processus d'implantation, les résistances auxquelles ils font face et les résultats obtenus permettent de mettre en évidence les orientations communes des politiques menées dans les deux pays et de souligner la nécessaire continuité et globalité de ces politiques pour impacter durablement l'organisation des soins (résumé de l'éditeur).

Paris V. (2013). Les modes de rémunération des médecins des pays de l'OCDE. In : Rémunérer les services de santé. *Sève : les Tribunes de la Santé* (40):
Abstract: Cet article décrit les principaux modes de rémunération des médecins généralistes et spécialistes dans les pays de l'OCDE. Ceux-ci sont liés aux modes d'organisation des soins, qui eux-mêmes dépendent du système de soins (système national versus assurance obligatoire). Depuis le début des années 2000, de nombreux pays ont complété les modes traditionnels de rémunération (salaire, capitation et paiement à l'acte) par des paiements additionnels visant à accroître la qualité des soins et l'efficience du système (résumé de l'éditeur).

Dormont B. (2013). Le paiement à la performance : contraire à l'éthique ou au service de santé publique ? In : Rémunérer les services de santé. *Sève : les Tribunes de la Santé* (40)
Abstract: Mis en place en 2012 sous la forme d'une «rémunération sur objectifs de santé publique», le paiement à la performance a conduit en France au versement d'une rémunération moyenne de 4752 euros aux omnipraticiens. À l'origine ce type de paiement avait soulevé l'opposition du Conseil de l'ordre et de nombreuses critiques émanant de médecins et de chercheurs en sciences sociales. Face à ces oppositions de principe, l'état des lieux montre une variabilité considérable des pratiques en médecine ambulatoire et une prise en charge des maladies chroniques insuffisante chez la majorité des médecins. C'est pourquoi il est conforme à l'éthique de chercher à modifier les comportements afin d'encourager les actes préventifs et d'améliorer l'accès de tous à des soins de qualité. Cependant, comme toute incitation financière, le paiement à la performance peut avoir des effets contraires aux objectifs recherchés. Il est donc important qu'il ne constitue qu'une partie limitée de la rémunération du médecin et qu'une évaluation rigoureuse de ses effets soit systématiquement réalisée(résumé de l'éditeur).

(2013). Patient et professionnels de santé : décider ensemble. Concept, aides destinées aux patients et impact de la « décision médicale partagée » : Saint-Denis La Plaine : HAS.
Abstract: La décision médicale partagée correspond à l'un des modèles de décision médicale qui décrit deux étapes clés de la relation entre un professionnel de santé et un patient que sont l'échange d'informations et la délibération en vue d'une prise de décision acceptée d'un commun accord concernant la santé individuelle d'un patient. Des aides à la décision destinées aux patients peuvent être proposées et ont fait preuve de leur efficacité pour augmenter la participation du patient qui le souhaite aux décisions qui concernent sa santé. Associées à d'autres mesures organisationnelles, elles peuvent améliorer la qualité et la sécurité des soins. Le contenu de ces aides vise à : rendre explicite la décision à prendre et les raisons qui nécessitent qu'elle soit prise ; guider le patient afin qu'il hiérarchise les options disponibles selon ses préférences en fonction des bénéfices et des risques qui ont de la valeur, de l'importance pour lui, et de son degré de certitude vis-à-vis de ses préférences ; expliciter les étapes du processus décisionnel et de communication avec les autres personnes impliquées dans la décision (médecin, famille, proches).
http://www.has-sante.fr/portail/upload/docs/application/pdf/2013-10/12iex04_decision_medicale_partagee_mel_vd.pdf

Alexander A. (2013). Does Physician Compensation Impact Procedure Choice and Patient Health? Princeton : Princeton University
Abstract: This paper finds that compensation structure impacts a doctor's decision to perform a Cesarean section (C-section). Using Medicaid reimbursement and vital statistics data, I find that fee-for-service doctors respond to an increase in the relative reimbursement for C-sections by increasing their use of the procedure. These incentives are not passed through to salaried doctors – their C-section use remains constant at the same lower rate as fee-for-service doctors who are paid the same for both procedures. For fee-for-service doctors who face pay differentials, however, the increase in C-section use due to increases in the pay difference is associated with fewer infant deaths. Thus, this paper demonstrates the difficulty in lowering procedure use while holding patient health constant; from a policy perspective, the consequences for patients of changing physician behavior must always be kept in mind.
http://wws-roxen.princeton.edu/chwpapers/papers/ALEXANDER_D_Jul13.pdf

Kringos D. (2013). The strength of primary care in Europe : an international comparative study. *British Journal of General Practice //,* 63 (616) :

Beckman A. (2013). Changes in health care utilisation following a reform involving choice and privatisation in Swedish primary care: a five-year follow-up of GP-visits. *Bmc Health Services Research,* 13 (452) :
Abstract: Background: The organisation of Swedish primary health care has changed following introduction of free choice of provider for the population in combination with freedom of establishment for private primary care providers. Our aim was to investigate changes in individual health care utilisation following choice and privatisation in Swedish primary care from an equity perspective, in subgroups defined by age, gender and family income. Methods: The study is based on register data years 2007 – 2011 from the Skåne Regional Council (population 1.2 million) regarding individual health care utilisation in the form of visits to general practitioner (GP). Health utilisation data was matched with data about individual's age, gender and family income provided by Statistics Sweden. Multilevel, logistic regression models were constructed to analyse changes in health utilisation in different subgroups and the probability of a GP-visit before and after reform. Results: Health care utilisation in terms of both number of individuals that had visited a GP and number of GP-visits per capita increased in all defined subgroups, but to a varying degree. Multilevel logistic regression showed that individuals of both genders aged above 64 and belonging to a family with an income above median had more advantage of the reform, OR 1.25-1.29. Conclusions: Reforms involving choice and privatisation in Swedish primary health care improved access to GP-visits generally, but more so for individuals belonging to a family with income above the median.

Systèmes de santé / Health Systems

Thomson S. O. 2013). International Profiles of Health Care Systems, 2013 : New York : The Commonwealth Fund //.
Abstract: This publication presents overviews of the health care systems of Australia, Canada, Denmark, England, France, Germany, Japan, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States. Each overview covers health insurance, public and private financing, health system organization and governance, health care quality and coordination, disparities, efficiency and integration, use of information technology and evidence-based practice, cost containment, and recent reforms and innovations. In addition, summary tables provide data on a number of key health system characteristics and performance indicators, including overall health care spending, hospital spending and utilization, health care access, patient safety, care coordination, chronic care management, disease prevention, capacity for quality improvement, and public views.
http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Nov/1717_Thomson_intl_profiles_hlt_care_sys_2013_v2.pdf

Hofmarcher M.M. (2013). Health system review :Austria. Health systems in transition ; vol. 15, n°7. Copenhague : OMS Bureau régional de l'Europe
Abstract: The Health Systems in Transition (HiT) series provide detailed descriptions of health systems in the countries of the WHO European Region as well as some additional OECD countries. An individual health system review (HiT) examines the specific approach to the organization, financing and delivery of health services in a particular country and the role of the main actors in the health system. It describes the institutional framework, process, content, and implementation of health and health care policies. HiTs also look at reforms in progress or under development and make an assessment of the health system based on stated objectives and outcomes with respect to various dimensions (health status, equity, quality, efficiency, accountability). This new Hit for Austria reports that Austrians are much more satisfied with their health system than most of their fellow Europeans. This could be explained by the high level of coverage and provider choice that Austrian patients generally enjoy and by the decentralized planning and governance of the system that allows to cater for local needs and preferences. However these same factors are also likely to generate fragmentation and lack of coordination, which makes the Austrian health system more costly than average and could hamper its performance. This is why since 2005, with the creation of the Federal Health Agency and regional health platforms, reform is aimed at intensifying cross-stakeholder coordination at all levels and promoting outpatient care.
http://www.euro.who.int/__data/assets/pdf_file/0017/233414/HiT-Austria.pdf

Siciliani L., Moran V., Borowitz M. 2013). Measuring and Comparing Health Care Waiting Times in OECD Countries : Paris : OCDE.
Abstract: Waiting times for elective (non-emergency) treatments are a key health policy concern in several OECD countries. This study describes common measures on waiting times across OECD countries from administrative data. It focuses on common elective procedures, like hip and knee replacement, and cataract surgery, where waiting times are notoriously long. It provides comparative data on waiting times across twelve OECD countries and presents trends in waiting times in the last decade. Waiting times appear to be low in the Netherlands and Denmark. In the last decade the United Kingdom (in particular England), Finland and the Netherlands have witnessed large reductions in waiting times which can be attributed to a range of policy initiatives, including higher spending, waiting-times target schemes, and incentive mechanisms which reward higher levels of activity. The negative trend in these countries has however halted in recent years and in some cases reverted. The analysis also emphasizes systematic differences across different waiting-time measures, in particular between the distribution of waiting times of patients treated versus the one of patients on the list. For example, the mean waiting time of patients on the list is generally higher than the mean waiting time of patients treated though we can find examples of the opposite. Mean waiting times are systematically higher than median waiting times and the difference can be quantitatively large.

Ehlert A. (2013). Cost Containment and Managed Care:Evidence from German Macro Data : Luneburg : University of Luneburg
Abstract: The major German health care reforms undertaken since the late 1990s resulted in the adoption of selective contracting mechanisms in a formerly sectorally separated health care system. These reforms marked the launch of managed care in Germany that is expected to yield both a higher quality of care and cost containment. We investigate if managed care had an influence on the structure of health care expenditure in Germany during the start-up phase of managed care from 2004 to 2008. We focus on pharmaceutical spending by statutory sickness funds (i.e. German law-enforced health insurance). We followed a macroeconomic evaluation approach based on a regional panel data set in contrast to previous research and were thus able to control for a comprehensive set of regional and demographic variables. We discuss alternative model specifications and include a range of sensitivity analyses. Our results suggest that in contrast to public perception the share of managed care contracts has a positive impact on pharmaceutical spending.
http://www.leuphana.de/fileadmin/user_upload/Forschungseinrichtungen/ifvwl/WorkingPapers/wp_284_Upload.pdf

Travail et santé / Occupational Health

Lechmann D.S.J. (2013). Absence from work of the self-employed: A comparison with paid employees : Erlangen : Universität Erlangen-Nürnberg
Abstract: Utilising a large representative data set for Germany, this study contrasts absenteeism of self-employed individuals and paid employees. We find that absence from work is clearly less prevalent among the self-employed than among paid employees. Only to a small extent, this difference can be traced back to differences in health status and job satisfaction. Furthermore, the gap in absenteeism is apparently not driven by different behaviour in case of sickness as we find no difference in the prevalence of presenteeism between the two groups. We suspect that different behaviour in case of healthiness plays a role, highlighting potential shirking and moral hazard problems in paid employment.
http://econstor.eu/bitstream/10419/86159/1/770666612.pdf

Vieillissement / Aging

Arnault L. (2013). How would informal caregivers react to an increase in formal home-care use by their elderly dependent relatives in France? Paris :Université Paris Dauphine
Abstract: This paper focuses on the trade-off between formal and informal care for disabled elderly people living at home in France. Using the French 2008 household Disability - Healthcare data (Handicap Santé Ménages - HSM 2008), we aim to elucidate the effect of an increase in formal home-care hours on the participation of informal caregivers. We expand on the previous literature, which almost exclusively focuses on the effect of informal care on formal home care. We estimate a bivariate Tobit model to account for both the censor and the potential endogeneity of our formal home-care variable. Our results confirm that crowding out of informal caregivers arises when the elderly dependent receives more hours of formal home care. Nevertheless, the crowding out of informal caregivers that arises when only personal formal home care increases is much weaker. Such crowding out can be interpreted negatively as a renouncement of informal caregivers, but it may also allow some of these caregivers to work more or re-enter the labor market.

Godard M. (2013). Gaining weight through retirement? Results from the SHARE survey : Paris :Université Paris Dauphine
Abstract: In this paper, we use IV-techniques to identify the causal effect of retirement among the 50-69 year-old on Body Mass Index (BMI) and related weight measures. Based on the 2004 and 2006 waves of the Survey of Health, Ageing and Retirement in Europe (SHARE), the identification strategy exploits the European variation in retirement schemes to produce an exogeneous shock in retirement behaviour. Our results show that retirement induced by discontinuous incentives in social security systems causes a 0.20 point increase in the probability of being overweight or obese.
http://www.legos.dauphine.fr/fileadmin/mediatheque/recherche_et_valo/LEGOS/document_de_travail_n__1_2013_01.pdf

Dujardin C. (2013). Self-Assessed Health of Elderly People in Brussels: Does the Built Environment Matter? Louvain-la-Neuve : CORE
Abstract: The built environment plays a key role in the strategy of “Aging in Place”. Here, we study the influence of the built environment on the health status of elderly people living in Brussels. Using census and geocoded data, we analysed if built environment factors were associated with poor self-assessed health status and functional limitations of elderly aged 65+. We concluded that the evidence of the builtenvironment hypothesis is weak and vulnerable to the composition of the neighborhood.
http://www.ecore.be/DPs/dp_1379577875.pdf

Cremer H. (2013). Uncertain altruism and the provision of long term care : Louvain-la-Neuve : CORE
Abstract: This paper studies the role of private and public long term care (LTC) insurance programs in a world in which family assistance is uncertain. Benefits are paid in case of disability but cannot be conditioned (directly), due to moral hazard problems, on family aid. Under a topping up scheme, when the probability of altruism is high, there is no need for insurance. At lower probabilities, insurance is

required, thought not full insurance. This can be provided either privately or publicly if insurance premiums are fair, and publicly otherwise. Moreover, the amount of LTC insurance varies negatively with the probability of altruism. With an opting out scheme, there will be three possible equilibria depending on the children's degree of altruism being "low," "moderate," or "very high". These imply: full LTC insurance with no aid from children, less than full insurance just enough to induce aid, and full insurance with aid. Fair private insurance markets can support the first equilibrium, but not the other two equilibria. Only a public opting-out scheme can attain them by creating incentives for self-targeting and ensuring that only dependent parents who are not helped by their children seek help from the government.
http://uclouvain.be/cps/ucl/doc/core/documents/coredp2013_47web.pdf

Brenna E. Di Novi C. (2013). Is caring for elderly parents detrimental for women's mental health? The influence of the European North-South gradient : Venice : University Ca' Foscari of Venice
Abstract: In the last decades, both the lengthening of life expectancy and an accentuated decline in birth rates have reduced the consistency of the younger generational cohorts. Due to ageing population, the burdens of caregiving are projected to intensify in the next quarter of the century in Europe, especially for mature women. This paper investigates the impact of the provision of constant care for elderly parents on the mental health of adult daughters, between the ages of 50 and 65, living in different European countries. Data is collected from the Survey of Health, Ageing and Retirement in Europe (SHARE). Information on mental health status is provided by Euro-D depression scale, a standardized measure of depression employed across European countries. We focus on differences in the effects according to a North–South gradient: we test whether the relationship between informal caregiving and mental health differs across European macro- regions. Our results reveal the presence of a North-South gradient in the effect of caring on women's mental health.
http://www.unive.it/media/allegato/DIP/Economia/Working_papers/Working_papers_2013/WP_DSE_brenna_dinovi_23_13.pdf

Hospido L. (2013). Retirement patterns of couples in Europe : Madrid : Banco de Espana
Abstract: In this paper we study the retirement patterns of couples in a multi-country setting using data from the Survey of Health, Aging and Retirement in Europe. In particular, we test whether women's (men's) transitions out of the labor force are causally related to the actual realization of their husbands' (wives') transition, using the institutional variation in country-specific early and full statutory retirement ages to instrument the latter. Exploiting the discontinuities in retirement behavior across countries, we find a significant joint retirement effect, especially for women, of around 16 to 18 percentage points. For men, we find a similar but less precise effect. Our empirical strategy allows us to give a causal interpretation to the effect we estimate. In addition, this effect has important implications for policy analysis.
http://www.bde.es/f/webbde/SES/Secciones/Publicaciones/PublicacionesSeriadas/DocumentosTrabajo/13/Fich/dt1317e.pdf